and also for the basis of a law in pharmacology, has not met with approval in certain quarters.

It is, of course, the concentration of salicyl in the joints as compared with that of the circulating blood that matters, and not the relative amounts in normal and diseased joints. Since the effusions of diseased joints, infected or inflamed or both, are derived from the blood, they would be expected to contain a greater absolute quantity of the drug than normal joints with their minimal amount of fluid. Except for the oversight of this important consideration, Bondi and Jacoby several years ago published experimental results on the distribution of salicyl in the joints of normal and infected rabbits, and thought they demonstrated the predilection of this drug for diseased joints. In fact, Bondi and Jacoby believed they discovered an important pharmacological law, namely, that pathological conditions inherently and characteristically modify the distribution and action of drugs. However, the character of the data of these authors scarcely warranted their conclusions, because they were based largely upon qualitative tests, which they employed, instead of quantitative estimations which are indispensable to the solution of such a problem. Although much has been made of these experiments of Bondi and Jacoby by text-book writers and investigators in various lines, it is apparent that they are wholly uncritical and unsatisfactory. The idea which they advanced was, nevertheless, an attractive one and stimulated investigations with drugs in various pathological conditions, though most of the results could have been predicted from a knowledge of the changed conditions. Recently, the distribution of salicyl in diseased joints has been investigated again by Fröhlich and Singer of Vienna.

The experiments of Fröhlich and Singer differ from the older ones of Bondi and Jacoby. In fact, they are an improvement. The Viennese investigators produced inflamed joints by the direct application of mustard and croton oils. The joints of one side were used for the experimental arthritis, while those of the other side served as controls. Then the animals were given large doses of salicylate, and the drug was estimated quantitatively in both sets of joints. The results showed no important differences between the inflamed and purulent, and the normal joints. There was frequently less salicyl in the inflamed than in the normal joints of the same animal, indicating that the swollen and inflamed membranes of the synovia acted as barriers to diffusion of the salicylate, if anything. No mention is made of the salicyl content of the blood by these authors.

As far as rheumatic fever is concerned, the distribution of salicyl in blood and the fluid of the inflamed joints in the same patient had been studied by Scott, Thoburn, and Hanzlik, several years ago. The concentration was found to be the same in both, namely, about 0.02 per cent, and sometimes less in the joint effusion than in the blood. Hence, the recent results of Fröhlich and Singer on rabbits agree with the older ones of Scott, Thoburn, and Hanzlik on patients. They show conclusively that there is no predilection of salicylate for the inflamed joints of experimental animals and those of rheumatic fever in patients, and furnish no evidence of a pharmacological law indicating characteristic differences in drug behavior owing to pathological changes. As far as the mechanism of the beneficial action of salicylate in rheumatic fever is concerned, that is another matter and probably independent of any alleged specificity or selectivity of the drug.

Bondi and Jacoby: Beiträge z. chem. Physiol. u. Pathol., 1906, 7:514.
Fröhlich and Singer: Arch. exp. Path. Pharm., 1923, 99:185.
Scott, Thoburn and Hanzlik: J. Pharm. Exp. Therap., 1917, 9:217.

SHALL THE RICH PAY MORE?

The question of whether the amount of a physician's fee should vary with the patient's financial condition never has been settled to the satisfaction of all. Physicians usually calculate their charges in accordance with one or more of the following methods: (a) A fixed fee schedule of charges for all alike; (b) an optimum fee schedule on which all charges are made and from which discounts are made to meet varying financial conditions of patients; (c) a fee schedule based upon what the physician considers his time worth. Patients who can't afford the schedule are not given discounts, but are treated free and the rich are charged extra.

All people have an interest in this problem from the standpoint of economic justice. Physicians have the additional responsibility of expressing its fairest solution in the ethics governing their conduct. Friendly arbitration or the law must furnish the final decision where controversy prevents more amicable adjustments. The vast majority of physicians calculate the value of their services from a more or less elastic personal fee schedule which changes from time to time, depending upon the usual conditions governing life. Nearly all physicians also discount their fees from 10 per cent to 100 per cent for a considerable percentage of their patients.

An inquiry upon this point submitted to a series of successful physicians recently brought the information that they collected what they considered their services worth from only about one-third of their patients; another third paid part fees, and about one-third of their services were rendered without compensation of any kind. The California Medical Association has taken an advanced stand upon the question of fees by passing a resolution endorsing the plan of charging fees in accordance with the patient's ability to pay, from nothing up to what each physician recognizes as his personal fee schedule. If this practice were more generally employed and more generally understood by the public, every physician's office would become a "medical center," or a "health center," or a "clinic" of the very best kind. Of course, there are a few physicians who have reached that far from enviable position in public opinion whereby they can—and a few of them no doubt do—conduct the practice of their profession upon a cash register basis. However, there are plenty of the other kind—and good ones, too. Comparatively few physicians actually charge wealthy patients extra high fees. However, some do, and the subject is often discussed both by physicians and the public in general.

An editorial in a recent number of The Lawyers'

Magazine reviews the question of "Making the Rich Pay More" in an authoritative and interesting manner. The editorial states:

"An English judge is reported, not long since, to have upheld the right of a physician to charge a wealthy patient more than he would ask a poor man for similar services.

"There seems to be a conflict in the authorities, in this country, as to whether it is proper to prove the value of the estate of a person for whom medical services were rendered, or the financial condition of the person receiving such services, in estimating their value, in the absence of an express contract. Some decisions favor the admission of such evidence. Haley's Succession, 50 La. Ann. 840, 24 So. 285; Czarnowski v. Zeyer, 35 La. Ann. 796; Schoenberg v. Rose, 145 N. Y. Supp. 831. In other jurisdictions, however, such evidence may not be considered. Robinson v. Campbell, 47 Iowa, 625; Swift v. Kelly, Tex. Civ. App., 133 S. W. 901.

"In determining the value of professional services rendered, testimony as to the value of a deceased patient's estate has been held inadmissible in the absence of a recognized usage obtaining to graduate professional charges with reference to the financial condition of the person for whom such services are rendered, which had been so long established and so universally acted upon as to have ripened into a custom. Morrisett v. Wood, 123 Ala. 384, 82 Am. St. Rep. 127, 26 So. 307.

"On the question of the value of services rendered by a physician, it is stated by the court in Lange v. Kearney, 21 N. Y. S. R. 262, 4 N. Y. Supp. 14, affirmed in 127 N. Y. 676, 28 N. E. 255: 'There is also evidence tending to establish a custom or rule of guidance as to charges of physicians for services rendered, and which makes the amount dependent upon the means of the patient, his financial ability, or condition; but this is a benevolent practice which does not affect the abstract question of value, or impose any legal obligation to adopt it, and cannot be said to be universal on the evidence. Indeed, there does not seem to exist any standard by which, in the application of the rule, the amount to be paid can be ascertained.'

"Whatever may be the true principle governing this matter in contracts, the court, in one case at least, is of the opinion that the financial condition of a patient cannot be considered, where there is no contract, and recovery is sustained on a legal fiction. Cotnam v. Wisdom, 83 Ark. 601, 119 Am. St. Rep. 157, 104 S. W. 164, 13 Ann. Cas. 25, 12 L. R. A. (N. S.) 1090."

The problem of physicians' fees is now much in the public eye everywhere as a result of the recent controversy between the Ford hospital authorities, on the one hand, and those of the Medical Society of Detroit Academy of Medicine, on the other hand. The Ford hospital appears to be conducted upon somewhat the same basis that a factory is conducted. Costs of service are accurately figured and charges are made to all alike upon that basis, regardless of the patient's ability to pay. This, insofar as his private hospital charges are concerned, while much criticized upon ethical grounds, is nevertheless conceded to be Ford's business.

The trouble seems to be that, in order to reach machine perfection, a definite price was fixed for each medical and surgical service, and there was to be no more flexibility in that charge than in the charge for the rent of a room or the price of an automobile. Doctors not on the salaried hospital payroll objected—and properly so—to the principle involved. Nevertheless, if we understand the situation, Ford is doing precisely what insurance companies (life and accident); governments (national, state, and local); hospital associations; life extension institutes; fraternal organizations, with sick benefits; clinics of the pay species, and many, many others in the medical field are doing.

The controversy is as old as man, and it is no nearer a solution now than it was a generation ago. The fundamentals are clear, but are usually overlooked. It is primarily a question as to whether the promotion of health and the prevention and treatment of disease is to be carried on as a private arrangement between agent and consumer or whether it is to become a great organized public utility where everyone is served like they are by a transportation system, for example: Buy your ticket or secure a free pass and ride on the train that is available and accept the conductor you happen to draw.

It is interesting in this connection to inform our members that there is a movement on foot to try to have the next California legislature declare health and medical service to be a public utility and thus place its supervision under control of the state. What are you going to do about it?

DO YOU WISH TO DISCUSS PAPERS PUBLISHED IN CALIFORNIA AND WESTERN MEDICINE?

Some two years ago a new method of discussing papers published in CALIFORNIA AND WESTERN MEDICINE was instituted. Instead of publishing the offhand extemporaneous remarks made at the medical meeting at the time the paper was presented, the finished copy of the manuscript has been and is being sent to discussants, who consider carefully and write what they have to say.

This practice quickly became so popular that, in order to give all members who wished it a chance to discuss papers, a reply postcard was sent to our mailing list in California, Utah and Nevada. This card simply asked the member if he wished his name added to the list of discussants of papers, and if so, he was asked to check from some sixteen headings the subject or subjects he would like to discuss.

Some 4500 cards were sent out; many of them returned the reply part of the card unsigned. A few indicated that they were not interested and two criticized the movement. All others indicated their desire to discuss papers and checked from one to four specialties and subjects they were interested in. This list has been tabulated under headings, and manuscripts are divided up between them, in accordance with the subject of the paper. The author of a paper is also given the privilege of naming one or more discussants. The results you are seeing in every number of CALIFORNIA AND WESTERN MEDICINE.

There are constantly in circulation from twenty to a hundred manuscripts, and as the work has evolved we figure that from six hundred to a thousand physicians will express themselves briefly upon important subjects of medicine every year.

There is no mistaking the value of this service to the cause of better medicine, nor to both authors and discussants. This is proved by the hundreds of com-